

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH Items 8 & 9 film G286 5/8/61 ink from Balto. City Health Dept.											
1. PLACE OF DEATH a. COUNTY Howard				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY in 1b M			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 999 Baltimore National Pike				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LOUIS FRANCIS BROWN Sr.				4. DATE OF DEATH April 25, 1961				5. SEX Male			
6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH May 29, 1903 1904			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Transportation				10b. KIND OF BUSINESS OR INDUSTRY Baltimore Sun				9. AGE (In years last birthday) 56 57 yrs.			
11. BIRTHPLACE (State or foreign country) Baltimore, Md				12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Jasper R. Brown				14. MOTHER'S MAIDEN NAME Emma Ludwig							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or service)				16. SOCIAL SECURITY NO. 213-03-2522				17. INFORMANT Mrs. Carrie F. Brown, 999 Baltimore National Pike			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE George E. Burgtorf				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED April 25, 1961			
EXAMINER'S NAME (Type) George E. Burgtorf M D				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-29-61				22c. NAME OF CEMETERY OR CREMATORY Cathedral			
22d. LOCATION (City, town, or country) Baltimore, Md				(State)							
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md				ADDRESS				24a. REC'D BY REGISTRAR APR 28 '61			
24b. REGISTRAR'S SIGNATURE Charles S. Kraus											

VS. A15ME  
5M 7/59

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11, 12, 13

NOTE: FOR

11-12-13

11-12-13

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

4379  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04372

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> c. LENGTH OF STAY in lb <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>In woods, 1 mi. from Mr. Faulkners Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKRIDGE</b> d. STREET ADDRESS <b>Box 159 -Hanover Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN HENRY CHANEY, JR.</b>		4. DATE OF DEATH Month Day Year <b>April 13, 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/06</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if railroad) <b>Welder and Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. R.R.</b>	9. AGE (In years last birthday) <b>55 yrs.</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Elkridge, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Henry Chaney</b>		14. MOTHER'S MAIDEN NAME <b>Martha R. Reigle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes - World War #2</b>		16. SOCIAL SECURITY NO. <b>XXXXX</b>	
17. INFORMANT <b>Mrs. Evelyn Marcovitch (sister)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Alcoholism.</b> <b>581.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fatty metamorphosis of the liver.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr., M.D.</b>		DATE SIGNED <b>April 14, 1961</b>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/17/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>	22d. LOCATION (City, town, or country) (State) <b>Elkridge, Maryland</b>
23. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR <b>APR 17 '61</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION



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Howard H. Hubbard 6107 Wilkins Ave.

Howard H. Hubbard (Mrs) 6107 Wilkins Ave.

Howard H. Hubbard 6107 Wilkins Ave.

Howard H. Hubbard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4380

## CERTIFICATE OF DEATH

04373

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howard</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Friendship</u>		c. LENGTH OF STAY IN 1b <u>Rife</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Friendship</u>		d. STREET ADDRESS <u>Route 144</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Sarah</u> First <u>Louisa</u> Middle <u>Cross</u> Last				<b>4. DATE OF DEATH</b> <u>April</u> Month <u>12</u> Day <u>1961</u> Year			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 19, 1878</u>	
<b>9. AGE</b> (In years last birthday) <u>82</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Basil T. Grimes</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Charity Ellen Selby</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Mrs. Edward R. Schwab</u> Address <u>Proctor, N.Y.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Convulsive disorder, etiology undetermined</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I attended the deceased from</b> <u>July 2</u> , 19 <u>48</u> , to <u>April 12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>61</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.	
<b>ACTUAL SIGNATURE</b> <u>Charles S. Whitaker</u> , M.D.				<b>DATE SIGNED</b> <u>Clarksville, Maryland</u> <u>4-12-61</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>Charles S. Whitaker, M.D.</u>				<b>22a. BURIAL, CREMATION, OR REMOVAL (Specify)</b> <u>Burial</u>			
<b>22b. DATE THEREOF</b> <u>4-15-61</u>		<b>22c. NAME OF CEMETERY OR CREMATOR</b> <u>St. Andrew</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Howard Co., Md.</u> (State)		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur H. Haight</u> ADDRESS <u>Clarksville, Md.</u>	
<b>24a. REC'D BY REGISTRAR</b> DATE <u>APR 17 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

CERTIFICATE OF DEATH

1918

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Place of birth  
6. Usual residence  
7. Occupation  
8. Education  
9. Marital status  
10. Name of father  
11. Name of mother  
12. Name of spouse  
13. Name of child  
14. Name of grandchild  
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99. Name of great-grandchild  
100. Name of great-grandparent

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Occupation

8. Education

9. Marital status

10. Name of father

11. Name of mother

12. Name of spouse

13. Name of child

14. Name of grandchild

15. Name of grandparent

16. Name of great-grandparent

17. Name of great-grandchild

18. Name of great-grandparent

19. Name of great-grandchild

20. Name of great-grandparent

21. Name of great-grandchild

1259

04374

V5. A15ME  
5M 7/59

STATE OF TEXAS  
COUNTY OF DALLAS  
CERTIFICATE OF DEATH

283



H. H.

Deceased  
Name

Age

Married, single, or a widow

Sex, race, color, and date of birth

Place of birth and date of death



Place of death and cause of death

Signature of physician

Signature of coroner

Signature of registrar

Signature of informant

Date

Filed

Signature of registrar

Signature of informant

Signature of registrar

Signature of informant

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VS A15 (4)  
 15M 9/55

4382

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04375

1. PLACE OF DEATH a. COUNTY <b>Howard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>SV01-4</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Md</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffers Convalescent Retreat</b>				d. STREET ADDRESS <b>218 Goodale Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>LOUISE R FEILD</b>				4. DATE OF DEATH Month Day Year <b>April 17 1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-20-1869</b>	9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Boydton Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>Willie Worthington</b>	
13. FATHER'S NAME <b>Rutledge P. Hughes</b>				14. MOTHER'S MAIDEN NAME <b>Willie Worthington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Alexander L. Feild, 218 Goodale Road, Baltimore Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peripheral Vascular Collapse</b> <b>578x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastro-Intestinal hemorrhage</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>28 hrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>46 Church Rd., Ellicott City, Md.</b>		(County)	(State)
21. I certify that I attended the deceased from <b>6-15</b> 19 <b>59</b> , to <b>4-17</b> 19 <b>61</b> , that I last saw the deceased alive on <b>4-17</b> 19 <b>61</b> , and that death occurred at <b>549</b> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Thomas F. Herbert, M.D. 46 Church Rd., Ellicott City, Md. 4-17-61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>4-19-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>		22d. LOCATION (City, town, or county) <b>Raleigh N.C.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>APR 19 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

MEDICAL CERTIFICATION

## HAWKLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

I VI I

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Live Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04376

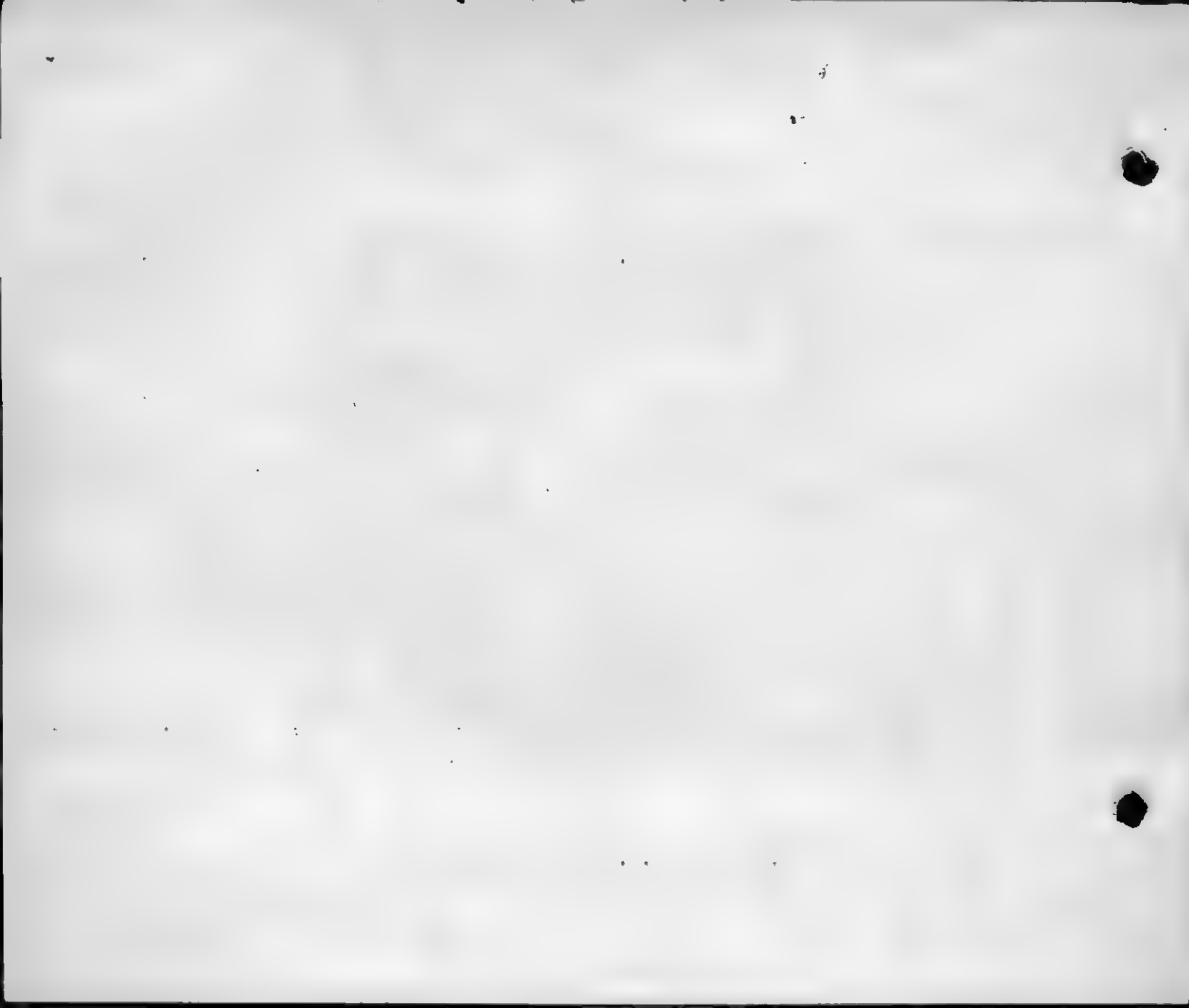
1. PLACE OF DEATH a. COUNTY <b>Howard</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Landon</b>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperville, Va</b>			
c. LENGTH OF STAY IN 1b <b>MARYLAND</b>				d. STREET ADDRESS <b>Amandale</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>South Gate Tourist Home</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROBERT W. GALL</b>				4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Sept 28, 1913</b>				9. AGE (In years last birthday) <b>47 yrs.</b> IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Horseman Race track</b>				11. BIRTHPLACE (State or foreign country) <b>Leesville S. Carolina</b>			
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Jacob Gall</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Smyre</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW 2</b>				17. INFORMANT <b>Frank Gall Charleston, W. Va.</b>			
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of liver</b> <b>5x1.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) INTERVAL BETWEEN ONSET AND DEATH <b>PARTIAL</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>PARTIAL</b>				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher</b>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>April 12 1961</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Batesburg Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Batesburg South Carolina</b>			
23. FUNERAL DIRECTOR <b>John L. Brown</b>				24a. REC'D BY REGISTRAR <b>APR 12 '61</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION



VS. A15ME  
5M 7/59

Arthur L. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4385

CERTIFICATE OF DEATH

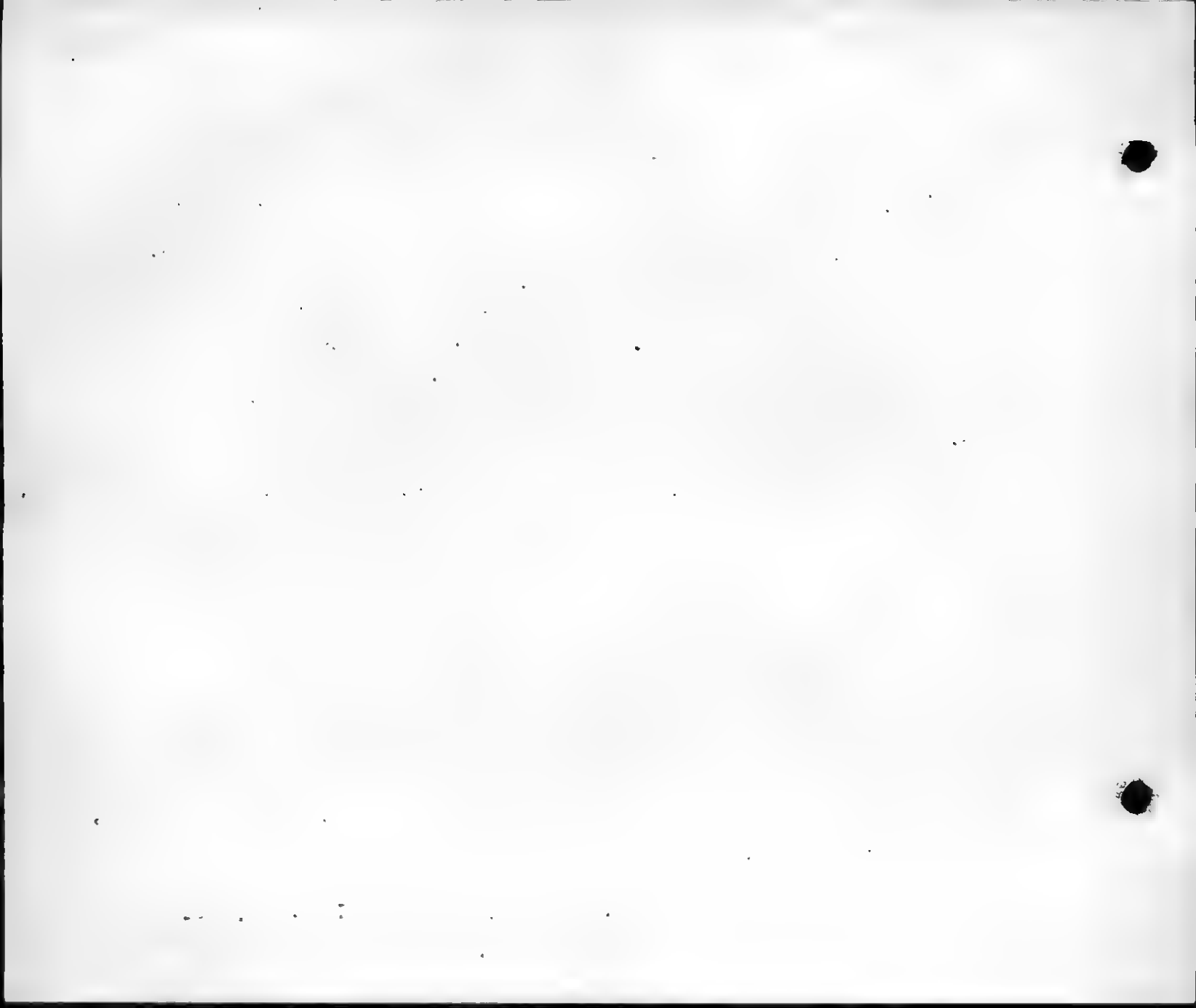
Reg. Dist. No.

04378

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u> c. LENGTH OF STAY IN 1b <u>46 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jennings Chapel Road</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u> d. STREET ADDRESS <u>Jennings Chapel Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Al</u> Middle <u>Marion</u> Last <u>Justice</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1884</u> 9. AGE (In years last birthday) <u>76</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Eugene Justice</u>	
14. MOTHER'S MAIDEN NAME <u>Helena Truitt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212-32-1500A</u>		17. INFORMANT Address <u>Mrs. Marion Justice, Woodbine, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>1. D.U.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Less than 6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>61</u> , to <u>April</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>61</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.		ADDRESS (Street, city or town, state) <u>900 S. Main</u> DATE SIGNED <u>4/14/61</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		<u>MT Airy, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/17/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jennings Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Florence, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Trifolanth</u> ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 18 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
4386 CERTIFICATE OF DEATH 04379															
1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u> c. LENGTH OF STAY IN 1b <u>40 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Blvd</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u> d. STREET ADDRESS <u>Washington Blvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Elizabeth Leakin Oberlin</u>				4. DATE OF DEATH <u>April 24 1961</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>May 28 1879</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Hammond Beann</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Shipley</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Mrs Elizabeth Marshall Jessup</u> Address <u>1411</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Coronary &amp; Myocardial Insuff.</u> DUE TO (c) <u>1 year.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year.</u>															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year <u>April 24 1961</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.) <u>Home</u> 20f. (City or town) <u>Jessup</u> (County) <u>Howard</u> (State) <u>Md</u>															
21. I certify that (I) (this hospital) attended the deceased from <u>April 24 1961</u> to <u>April 24 1961</u> that (I) (we) last saw the deceased alive on <u>April 24 1961</u> and that death occurred at <u>9 PM</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Frank E. Shipley</u> M.D. 22b. DATE SIGNED <u>4/25/61</u>															
22c. PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u> 22d. ADDRESS <u>Swage, Inc.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/27/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> 23d. LOCATION (City, town or county) <u>Dorsey Md</u> (State) <u>Md</u>															
24. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Carson</u> ADDRESS <u>Laurel, Md</u> 25a. REC'D BY REGISTRAR <u>DATE MAY 1 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>															



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
 15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

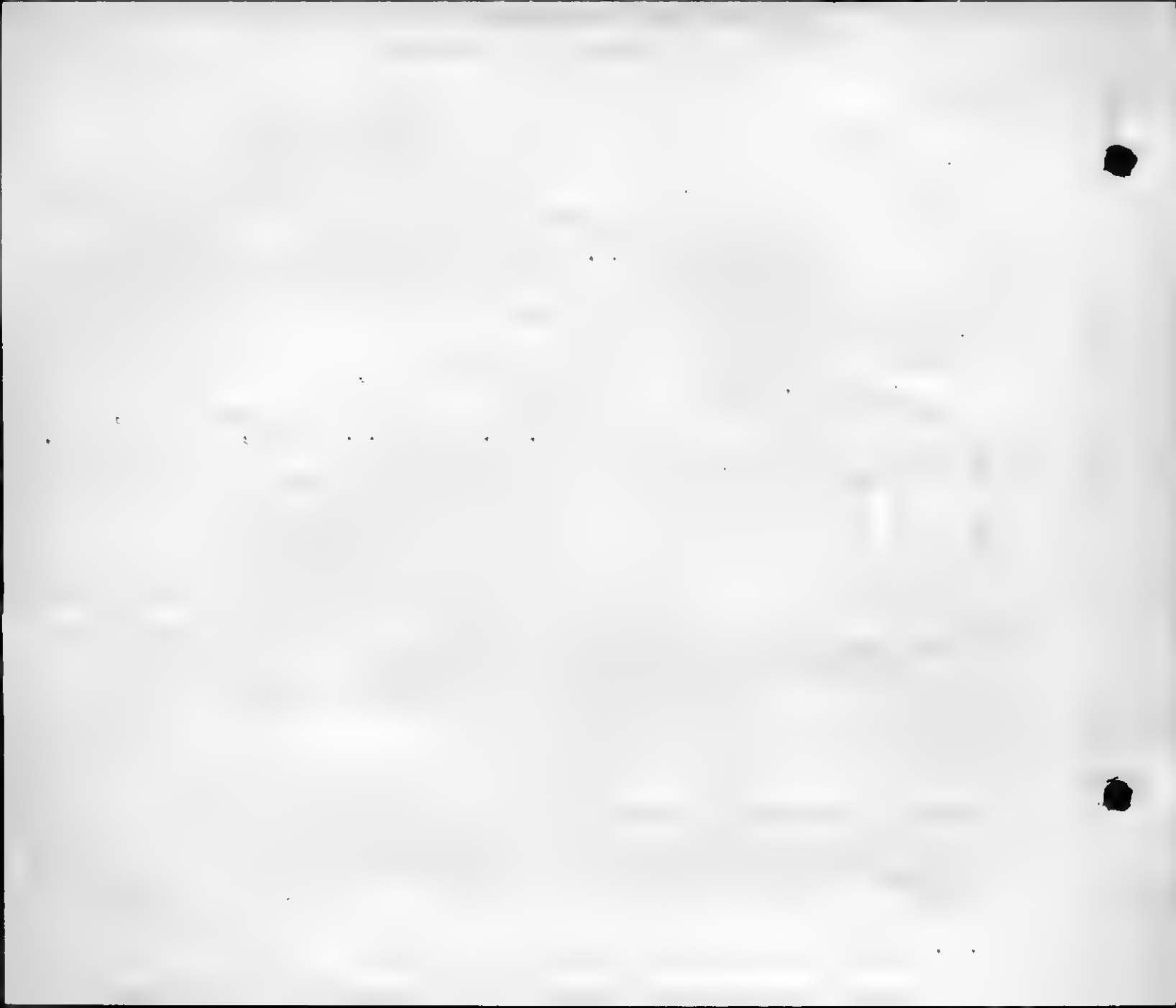
## CERTIFICATE OF DEATH

Reg. Dist. No.

04380

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
c. LENGTH OF STAY IN 1b <b>4 Years</b>				d. STREET ADDRESS <b>26 South Market Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaner Convalescent Retreat</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sophie</b> Middle <b>A.M.</b> Last <b>Raabe</b>				4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 21, 1872</b>	
9. AGE (In years last birthday) <b>88</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>19</b> Min <b>19</b>		IF UNDER 24 HRS. Months <b>6</b> Days <b>6</b> Hours <b>19</b> Min <b>19</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Beauty Shop</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles M. Hermann</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Dehl</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Rev. Dr. Edward A.G. Hermann, Baltimore 29, Md.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> DUE TO <b>Arteriosclerotic Cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 yrs</b> (c) <b>36 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 24, 1957</b> , to <b>April 6, 1961</b> , that I last saw the deceased alive on <b>April 5, 1961</b> , and that death occurred at <b>2 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>46 Church Rd</b> DATE SIGNED <b>4-6-61</b>							
ACTUAL SIGNATURE <b>Thomas F. Herbert</b> M.D. <b>Ellicott City, Md</b>							
PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b> <b>Ellicott City, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4/8/1961</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>APR 10 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>C. L. S. Frank</b>							

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

Reg. Dist. No.

114381

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Howard</i>	MARYLAND	STATE <i>Ind</i>	COUNTY <i>Ind</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>JESSUP</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>JESSUP</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Box 348A Montevideo Rd</i>		STREET ADDRESS (if rural give location) <i>Box 348A Montevideo Rd</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>AGNES</i> (Middle) <i>N.</i> (Last) <i>HALEIGH</i>		(Month) <i>April</i> (Day) <i>12</i> (Year) <i>1961</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>8 Oct 1906</i>
9. AGE last birthday <i>54</i> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CLERK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>WGT STORES</i>	
11. BIRTHPLACE (State or foreign country) <i>CRISFIELD Ind</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>JAMES WEBSTER</i>		14. MOTHER'S MAIDEN NAME <i>MAY STERLING</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>215-30-0062</i>	
17. INFORMANT & ADDRESS <i>WALTER HALEIGH JESSUP Ind</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <i>2 months illness</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>2 mo. long illness to pneumonia</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Liver &amp; gall ph. nodules</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>inoperable cancer of the lungs</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>metastatic carcinoma of the lungs</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>April 12, 1961</i> to <i>April 12, 1961</i> , that I last saw the deceased alive on <i>4/10/61</i> , and that death occurred at <i>4:10 A.M.</i> from the causes and on the date stated above. <i>4/12/61</i>			
SIGNATURE <i>Walter HALEIGH</i> M.D.		ADDRESS (Street, city, town, state) <i>Box 348A Montevideo Rd</i> DATE SIGNED <i>4/12/61</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>14 April 1961</i>	
NAME OF CEMETERY OR CREMATORY <i>Meadowdale Cem</i>		LOCATION (City, town, or county) (State) <i>Jopsey Ind</i>	
24. REC'D BY REGISTRAR <i>APR 13 '61</i>		REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter HALEIGH</i>		ADDRESS <i>Box 348A Montevideo Rd</i>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this filing by the funeral director, the first copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MSC 1-55 10M





15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

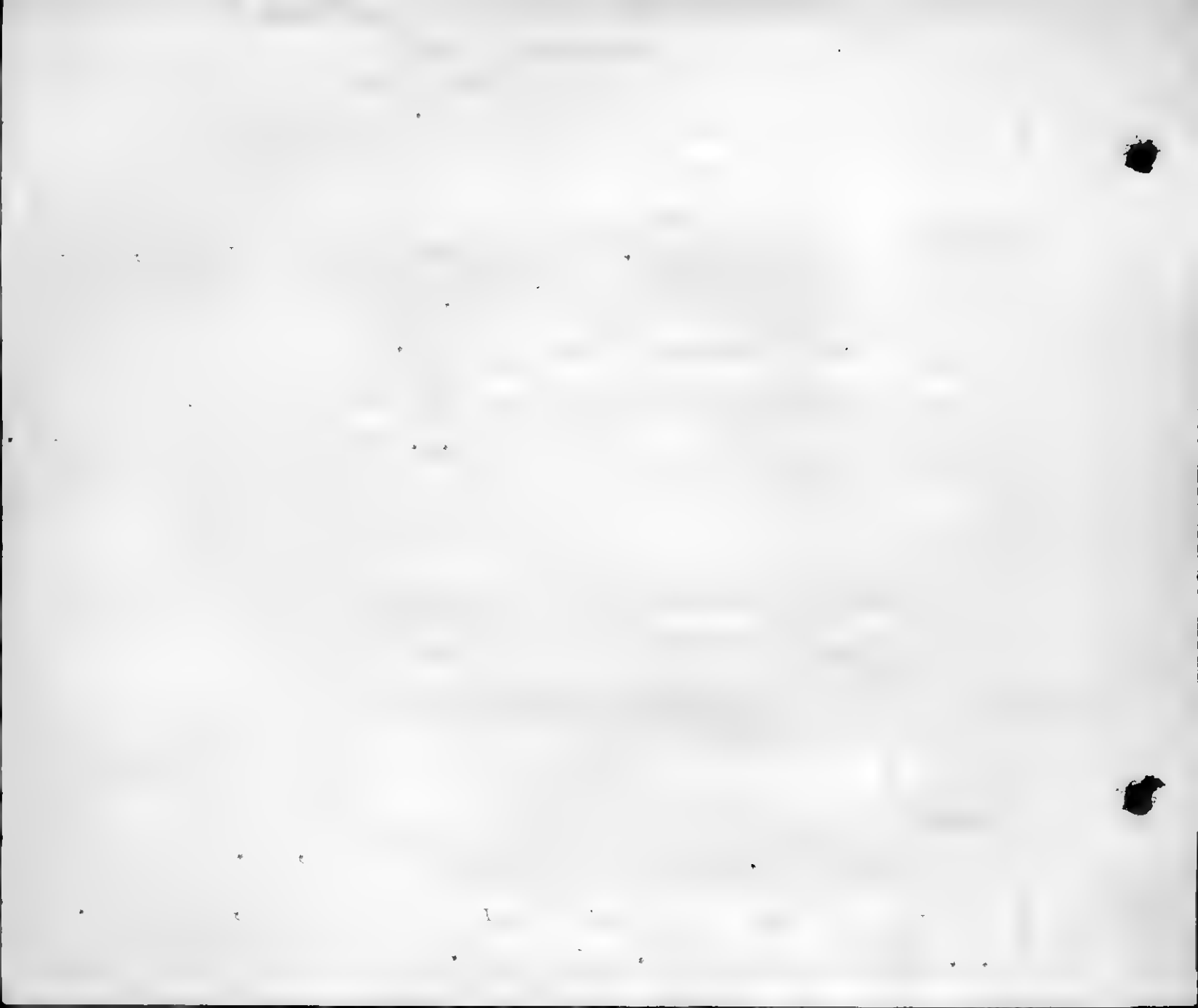
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4330

## CERTIFICATE OF DEATH

Reg. Dist. No. 04383

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>HOWARD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b>		c. LENGTH OF STAY IN 1b <b>35 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b>	
d. STREET ADDRESS <b>71 COLLEGE AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>W.</b> Last <b>SULLIVAN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 10, 1910</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER- CATHOLIC HIGH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNA.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ALFRED VICTOR WEAVER</b>		14. MOTHER'S MAIDEN NAME <b>GERTRUDE KLINE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT <b>NORBERT J. J. SULLIVAN ELLICOTT CITY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>Carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 2, 1960</b> to <b>April 29, 1961</b> , that I last saw the deceased alive on <b>April 29, 1961</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Ellicott City, Md.</b>	
ACTUAL SIGNATURE <b>William F. Gassaway</b>		DATE SIGNED <b>4/29/61</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM F. GASSAWAY</b>		<b>ELLICOTT CITY, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/2/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. MEARS &amp; SON</b>		ADDRESS <b>805 N. CALVERT ST</b>	
24a. REC'D BY REGISTRAR <b>MAY 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Hines</b>	



4391

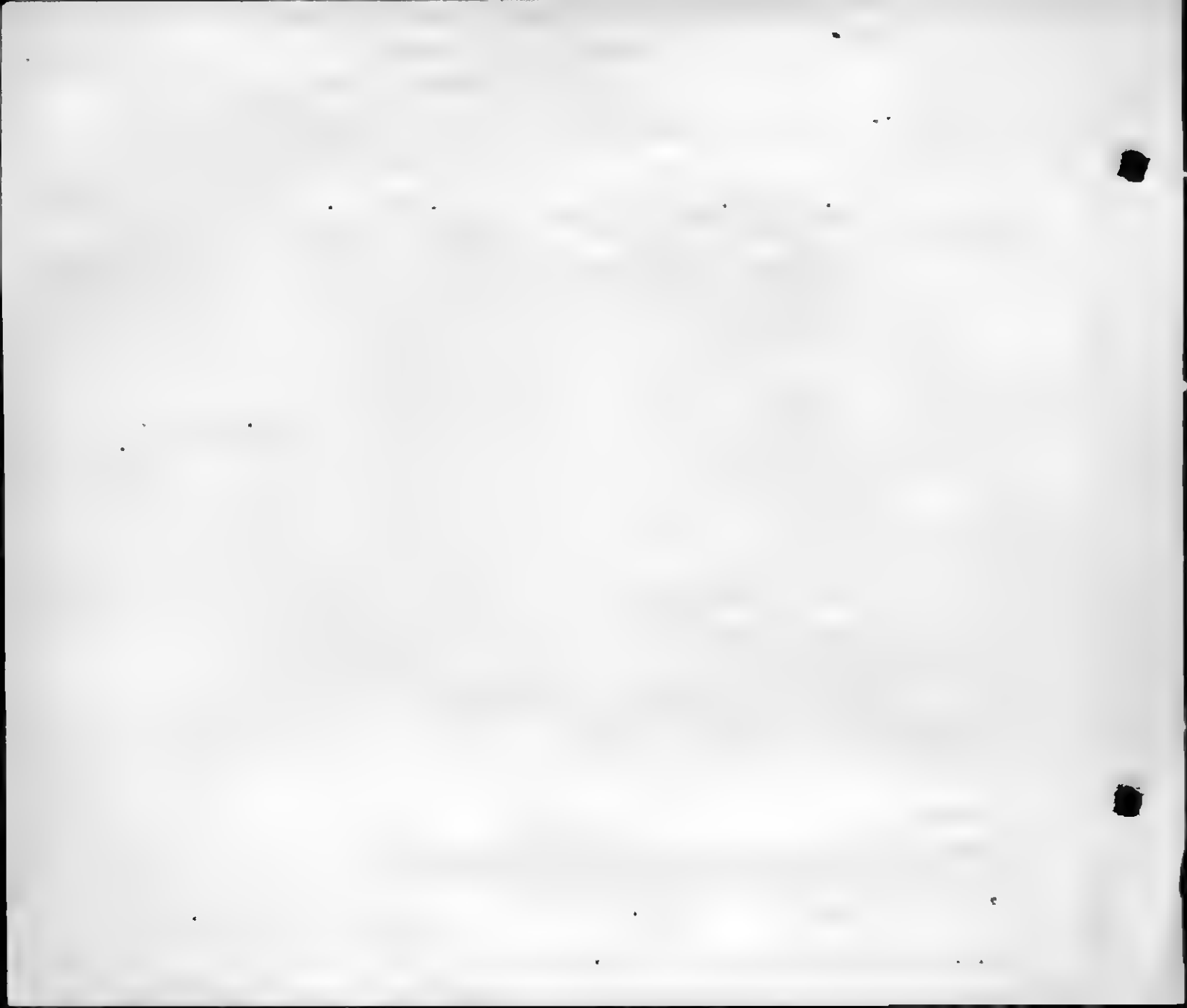
## CERTIFICATE OF DEATH

Reg. Dist. No. 04384

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>348 W. Main St.</u>		d. STREET ADDRESS <u>348 W. Main St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BRADLEY EARL TITTSWORTH</u>		4. DATE OF DEATH Month Day Year <u>April 16 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1904</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>auto</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Marshall Tittsworth</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-03-4295</u>	
17. INFORMANT <u>Mrs Angela Tittsworth</u>		Address <u>348 W. Main St, Ellicott City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Nephritis, Chronic with uremia, and myocarditis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 years</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 1959</u> to <u>April 16, 1961</u> , that I last saw the deceased alive on <u>9 PM</u> , 19 <u>61</u> , and that death occurred on <u>9 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Taylor</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>111 Columbia Rd Ellicott City Md</u> <u>4-17-61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/19/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>		ADDRESS <u>Ellicott City, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4392

CERTIFICATE OF DEATH

Reg. Dist. No. 04385

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Savage Guilford Rd</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Yvonne</u> Middle <u>Alta</u> Last <u>Talley</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1920</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Coun. home</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Harrison Hardy</u>				14. MOTHER'S MAIDEN NAME <u>May Ada Blum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Mr. Richard Talley</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET, AND DEATH <u>7 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>  </u> , 19 <u>61</u> , to <u>April 2, 1961</u> , that I last saw the deceased alive on <u>April 2, 1961</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert S. McCeney, M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>402 Main St. Laurel, Md.</u>			
DATE SIGNED <u>4/7/61</u>							
PHYSICIAN'S NAME (Type) <u>Dr. W. H. Connelley, Laurel, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 4, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Airy Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Connelley, Laurel, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. E. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4393

## CERTIFICATE OF DEATH

Reg. Dist. No.

04386

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>225 Main St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALEXIS</u> Middle <u>S.</u> Last <u>WILLIAMS</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25, 1877</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rural Mail Carrier</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Alexander Williams</u>				14. MOTHER'S MAIDEN NAME <u>Rose Ella Hanson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Leroy Williams, 2210 College St. Columbia, S.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>HTA 5 CVD</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 YRS</u> <u>5 YRS</u> <u>10 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6-6</u> , 19 <u>60</u> , to <u>4-26</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4-26</u> , 19 <u>61</u> , and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>409 Columbia Road</u> DATE SIGNED ACTUAL SIGNATURE <u>P. H. Thorpe</u> M.D. PHYSICIAN'S NAME (Type) <u>Peter Van B. Thorpe MD</u> <u>Ellicott City, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-30-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Star</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 04387

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <u>Harford</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brown Bridge Road</u>		d. STREET ADDRESS <u>Brown Bridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward S.</u> Middle <u>Wilson</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1895</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Edgar, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Leopold Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Carr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WW I</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Jessie E. Wilson, Highland Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery occlusion</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>instant.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Dec. 31, 1946</u> , to <u>April 7, 1961</u> , that I last saw the deceased alive on <u>March 14, 1961</u> , and that death occurred at <u>800 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>April 9, '61</u>					
ACTUAL SIGNATURE <u>Charles S. Whitaker, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u> <u>Clarksville, Maryland (Howard Co.)</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 11, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	
22d. LOCATION (City, town, or county)		22e. (State) <u>Bertanville Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. W. Davidson</u>		ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>Apr 12 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. King</u>					

CERTIFICATE OF DEATH

1924

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Place of registration</p>	